MANAGED CARE CHECKLIST:
REVIEW OF HEALTH MAINTENANCE ORGANIZATIONS
LICENSED UNDER M.GL. c. 176G

NOTE TO COMPANIES COMPLETING THIS CHECKLIST: ***Please include a completed checklist for each evidence of coverage when submitting an application for or material change to an insured preferred provider plan pursuant to M.G.L. c. 176I or an application for or material change to accreditation pursuant to M.G.L. c. 176O indicating, as applicable, the page number(s), and/or section(s), where the required information may be found in the submitted materials. Please indicate if a requirement is not applicable (N/A) and explain the reason(s) why.***

Carrier Name: _____

NAIC #: _____

Contact Name & Title: _____

Address: _____

Telephone: _____

Fax: _____

Email Address: _____

Date Received: _____

Reviewed by: _____

Product Name & Form #: _____

_____

_____

_____

_____

MANAGED CARE

Definitions from M.G.L. c. 176O, § 1 and 211 CMR 52.03 often used within policy forms or other submitted materials (if used)

_____ Adverse determination, "a determination, based upon a review of information provided, by a carrier or its designated utilization review organization, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness."

_____ Emergency medical condition, "a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in § 1867(e)(l)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B)."

_____ Medical necessity or medically necessary, "health care services that are consistent with generally accepted principles of professional medical practice as determined by whether:
(a) the service is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual;
(b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
(c) for services and interventions not in widespread use, is based on scientific evidence."

_____ Participating provider, "a provider who, under a contract with the carrier or with its contractor or subcontractor, has agreed to provide health care services to insureds with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the carrier."

_____ Utilization review, "a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review."

Standards for Utilization Review (See also Bulletin Nos. 02-04 and 01-10)

_____ According to 211 CMR 52.08(4), "[a] carrier or utilization review organization shall make an initial determination regarding a proposed admission, procedure or service that requires such a determination within two working days of obtaining all necessary information.

_____ (a) For purposes of 211 CMR 52.08(4), "necessary information" shall include the results of any face-to-face clinical evaluation or second opinion that may be required.

_____ (b) In the case of a determination to approve an admission, procedure or service, the carrier or utilization review organization shall notify the provider rendering the service by telephone within 24 hours, and shall send written or electronic confirmation of the telephone notification to the insured and the provider within two working days thereafter.

_____ (c) In the case of an adverse determination, the carrier or utilization review organization shall notify the provider rendering the service by telephone within 24 hours, and shall send written or electronic confirmation of the telephone notification to the insured and the provider within one working day thereafter."

_____ According to 211 CMR 52.08(5), "[a] carrier or utilization review organization shall make a concurrent review determination within one working day of obtaining all necessary information.

_____ (a) In the case of a determination to approve an extended stay or additional services, the carrier or utilization review organization shall notify the provider rendering the service by telephone within one working day, and shall send written or electronic confirmation to the insured and the provider within one working day thereafter. A written or electronic notification shall include the number of extended days or the next review date, the new total number of days or services approved, and the date of admission or initiation of services.

_____ (b) In the case of an adverse determination, the carrier or utilization review organization shall notify the provider rendering the service by telephone within 24 hours, and shall send written or electronic notification to the insured and the provider within one working day thereafter.

_____ (c) The service shall be continued without liability to the insured until the insured has been notified of the determination."

_____ According to 211 CMR 52.08(6), "[t]he written notification of an adverse determination shall include a substantive clinical justification therefor that is consistent with generally accepted principles of professional medical practice, and shall, at a minimum:

_____ (a) identify the specific information upon which the adverse determination was based;

_____ (b) discuss the insured's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;

_____ (c) specify any alternative treatment option offered by the carrier, if any;

_____ (d) reference and include applicable clinical practice guidelines and review criteria; and

_____ (e) a clear, concise and complete description of the carrier's formal internal grievance process and the procedures for obtaining external review pursuant to 105 CMR 128.400."

Please submit a copy of every adverse determination letter used by the carrier.

_____ According to 211 CMR 52.08(7), "[a] carrier or utilization review organization shall give a provider treating an insured an opportunity to seek reconsideration of an adverse determination from a clinical peer reviewer in any case involving an initial determination or a concurrent review determination.

_____ (a) The reconsideration process shall occur within one working day of the receipt of the request and shall be conducted between the provider rendering the service and the clinical peer reviewer or a clinical peer designated by the clinical peer reviewer if the reviewer cannot be available within one working day.

_____ (b) If the adverse determination is not reversed by the reconsideration process, the insured, or the provider on behalf of the insured, may pursue the grievance process established pursuant to 105 CMR 128.000.

_____ (c) The reconsideration process allowed pursuant to 211 CMR 52.08(6) shall not be a prerequisite to the internal grievance process or an expedited appeal required by 105 CMR 128.000."

_____ According to 211 CMR 52.08(8), "[a] carrier must provide evidence that its policies regarding continuity of care comply with all provisions of 105 CMR 128.500 through 128.503."

_____ According to 211 CMR 52.08(10), "[a] carrier or utilization review organization shall conduct an annual survey of insureds to assess satisfaction with access to specialist services, ancillary services, hospitalization services, durable medical equipment and other covered services.

(a) The survey shall compare the actual satisfaction of insureds with projected measures of their satisfaction.

(b) Carriers that utilize incentive plans shall establish mechanisms for monitoring the satisfaction, quality of care and actual utilization compared with projected utilization of health care services of insureds."

Requirements of Provider Contracts

Please see separate checklist.

Requirements of an Evidence of Coverage

(1) According to 211 CMR 52.13(1)(a)-(x) "[a] carrier shall issue and deliver to at least one adult insured in each household residing in Massachusetts, upon enrollment, an evidence of coverage. The evidence of coverage shall contain a clear, concise and complete statement of:

_____ (a) the health care services and any other benefits to which the insured is entitled on a nondiscriminatory basis, including benefits mandated by state or federal law; **[See Mandated Benefits section below]]**

_____ (b) the prepaid fee which must be paid by or on behalf of the insured and an explanation of any grace period for the payment of any premium;

_____ (c) the limitations on the scope of health care services and any other benefits to be provided, including an explanation of any deductible or copayment feature;

_____ (d) all restrictions relating to preexisting condition limitations or exclusions, or a statement that there are no preexisting condition limitations or exclusions if there are none under the health benefit plan;

_____ (e) the locations where, and the manner in which, health care services and other benefits may be obtained;

_____ (f) a description of eligibility of coverage for dependents, including a summary description of the procedure by which dependents may be added to the plan;

_____ (g) the criteria by which an insured may be disenrolled or denied enrollment;

_____ (h) the involuntary disenrollment rate among insureds of the carrier;

1. For the purposes of 211 CMR 52.13(1)(h), carriers shall exclude all administrative disenrollments, insureds who are disenrolled because they have moved out of a health plan's service area, insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or insureds who lose coverage under an employer-sponsored plan because they have ceased employment or because their employer group has cancelled coverage under the plan, reduced the numbers of hours worked, become disabled, retired or died.
2. For the purposes of 211 CMR 52.13(1)(h), the term "involuntary

disenrollment" means that a carrier has terminated the coverage of the insured due to any of the reasons contained in 211 CMR 52.13(1)(i)(2) and (3).

_____ (i) the requirement that an insured's coverage may be canceled, or its renewal refused, only in the following circumstances:

_____ 1. failure by the insured or other responsible party to make payments required under the contract;

_____ 2. misrepresentation or fraud on the part of the insured;

_____ 3. commission of acts of physical or verbal abuse by the insured which pose a threat to providers or other insureds of the carrier and which are unrelated to the physical or mental condition of the insured; provided, that the commissioner prescribes or approves the procedures for the implementation of the provisions of this clause;

_____ 4. relocation of the insured outside the service area of the carrier; or

_____ 5. non-renewal or cancellation of the group contract through which the insured receives coverage;

_____ (j) a description of the carrier's method for resolving insured inquiries and complaints, including a description of the internal grievance process consistent with 105 CMR 128.300 through 128.313, and the external review process consistent with 105 CMR 128.400 through 128.416;

_____ (k) a statement telling insureds how to obtain the report regarding grievances pursuant to 105 CMR 128.600(A)(4) from the Office of Patient Protection;

_____ (l) a description of the Office of Patient Protection, including its toll-free telephone number, facsimile number, and internet site;

_____ (m) a summary description of the procedure, if any, for out-of-network referrals and any additional charge for utilizing out-of-network providers;

_____ (n) a summary description of the utilization review procedures and quality assurance programs used by the carrier, including the toll-free telephone number to be established by the carrier that enables consumers to determine the status or outcome of utilization review decisions; **[See Standards for Utilization Review above]**

_____ (o) a statement detailing what translator and interpretation services are available to assist insureds, including that the carrier will provide, upon request, interpreter and translation services related to administrative procedures. The statement must appear in at least Arabic, Cambodian, Chinese, English, French, Greek, Haitian-Creole, Italian, Lao, Portuguese, Russian and Spanish;

_____ (p) a list of prescription drugs excluded from any closed or restricted formulary available to insureds under the health benefit plan; provided, that the carrier shall annually disclose any changes in such a formulary, and shall provide a toll-free telephone number to enable consumers to determine whether a particular drug is included in the closed or restricted formulary.

1. A carrier will be deemed to have met the requirements of 211 CMR 52.13(1)(p) if the carrier does all of the following:

_____ a. provides a complete list of prescription drugs that are included in any closed or restricted formulary;

_____ b. clearly states that all other prescription drugs are excluded;

_____ c. provides a toll-free number that is updated within 48 hours of any change in the closed or restricted formulary to enable insureds to determine whether a particular drug is included in or excluded from the closed or restricted formulary; and

_____ d. provides an internet site that is updated as soon as practicable relative to any change in the closed or restricted formulary to enable insureds to determine whether a particular drug is included in or excluded from the closed or restricted formulary;

_____ (q) a summary description of the procedures followed by the carrier in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;

_____ (r) requirements for continuation of coverage mandated by state and federal law **[See Continuation of Coverage section below]**;

_____ (s) a description of coordination of benefits consistent with 211 CMR 38.00;

_____ (t) a description of coverage for emergency care and a statement that insureds have the opportunity to obtain health care services for an emergency medical condition, including the option of calling the local pre-hospital emergency medical service system, whenever the insured is confronted with an emergency medical condition which in the judgment of a prudent layperson would require pre-hospital emergency services;

(u) If the carrier offers services through a network or through participating providers, the following statements regarding continued treatment:

_____ 1. If the carrier allows or requires the designation of a primary care physician, a statement that the carrier will notify an insured at least 30 days before the disenrollment of such insured's primary care physician and shall permit such insured to continue to be covered for health services, consistent with the terms of the evidence of coverage, by such primary care physician for at least 30 days after said physician is disenrolled, other than disenrollment for quality related reasons or for fraud. The statement shall also include a description of the procedure for choosing an alternative primary care physician.

_____ 2. A statement that the carrier will allow any female insured who is in her second or third trimester of pregnancy and whose provider in connection with her pregnancy is involuntarily disenrolled, other than disenrollment for quality-related reasons or for fraud, to continue treatment with said provider, consistent with the terms of the evidence of coverage, for the period up to and including the insured's first postpartum visit.

_____ 3. A statement that the carrier will allow any insured who is terminally ill and whose provider in connection with said illness is involuntarily disenrolled, other than disenrollment for quality related reasons or for fraud, to continue treatment with said provider, consistent with the terms of the evidence of coverage, until the insured's death.

_____ 4. A statement that the carrier will provide coverage for health services for up to 30 days from the effective date of coverage to a new insured by a physician who is not a participating provider in the carrier's network if:

_____ a. the insured's employer only offers the insured a choice of carriers in which said physician is not a participating provider, and

_____ b. said physician is providing the insured with an ongoing course of treatment or is the insured's primary care physician.

_____ c. With respect to an insured in her second or third trimester of pregnancy, this provision shall apply to services rendered through the first postpartum visit. With respect to an insured with a terminal illness, this provision shall apply to services rendered until death.

_____ 5. A carrier may condition coverage of continued treatment by a provider under 211 CMR 52.13(1)(u)(1) through (4), inclusive, upon the provider's agreeing

_____ a. to accept reimbursement from the carrier at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the insured in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled;

_____ b. to adhere to the quality assurance standards of the carrier and to provide the carrier with necessary medical information related to the care provided; and

_____ c. to adhere to the carrier's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by the carrier.

_____ 6. Nothing in 211 CMR 52.13(1)(u) shall be construed to require the coverage of benefits that would not have been covered if the provider involved remained a participating provider.

(v) If a carrier requires an insured to designate a primary care physician, a statement that the carrier will allow the primary care physician to authorize a standing referral for specialty health care provided by a health care provider participating in the carrier's network when:

_____ 1. the primary care physician determines that such referrals are appropriate,

_____ 2. the provider of specialty health care agrees to a treatment plan for the insured and provides the primary care physician with all necessary clinical and administrative information on a regular basis, and

_____ 3. the health care services to be provided are consistent with the terms of the evidence of coverage.

_____ 4. Nothing in 211 CMR 52.13(v) shall be construed to permit a provider of specialty health care who is the subject of a referral to authorize any further referral of an insured to any other provider without the approval of the insured's carrier.

(w) If a carrier requires an insured to obtain referrals or prior authorization from a primary care physician for specialty care, a statement that the carrier will not require an insured to obtain a referral or prior authorization from a primary care physician for the following specialty care provided by an obstetrician, gynecologist, certified nurse midwife or family practitioner participating in such carrier's health care provider network and that the carrier will not require higher copayments, coinsurance, deductibles or additional cost sharing arrangements for such services provided to such insureds in the absence of a referral from a primary care physician:

_____ 1. annual preventive gynecologic health examinations, including any subsequent obstetric or gynecological services determined by such obstetrician, gynecologist, certified nurse midwife or family practitioner to be medically necessary as a result of such examination;

_____ 2. maternity care; and

_____ 3. medically necessary evaluations and resultant health care services for acute or emergency gynecological conditions.

_____ 4. Carriers may establish reasonable requirements for participating obstetricians, gynecologists, certified nurse midwives or family practitioners to communicate with an insured's primary care physician regarding the insured's condition, treatment, and need for follow-up care.

_____ 5. Nothing in 211 CMR 52.13(1)(w) shall be construed to permit an obstetrician, gynecologist, certified nurse midwife or family practitioner to authorize any further referral of an insured to any other provider without the approval of the insured's carrier.

_____ (x) A statement that the carrier will provide coverage of pediatric specialty care, including, for the purposes of 211 CMR 52.13(1)(x), mental health care, by persons with recognized expertise in specialty pediatrics to insureds requiring such services."

_____ According to 211 CMR 52.13(2), "[a] carrier shall issue and deliver to at least one adult insured in each household residing in Massachusetts, or in the case of a group policy, to the group representative, prior notice of material modifications in covered services under the health plan at least 60 days before the effective date of the modifications. The notices shall include the following: (a) any changes in clinical review criteria [and] (b) a statement of the effect of such changes on the personal liability of the insured for the cost of any such changes." **Please confirm that the carrier will comply with this requirement.**

_____ According to 211 CMR 52.13(3), "[a] carrier shall submit all evidences of coverage to the Division at least 30 days prior to their effective dates." **Please confirm that the carrier will comply with this requirement.**

_____ According to 211 CMR 52.13(4), "[a] carrier shall provide to at least one adult insured in each household residing in Massachusetts notice of all material changes to the evidence of coverage." **Please confirm that the carrier will comply with this requirement.**

_____ According to 211 CMR 52.13(5), "[e]vidences of coverage issued or renewed on or after July 1, 2001 must comply with all of the requirements of 211 CMR 52.13. Carriers shall issue to at least one adult insured in each household whose coverage renews between July 1, 2001, and June 30, 2002, an evidence of coverage upon renewal that complies with 211 CMR 52.13. Carriers may provide notice of material changes by issuing riders, amendments or endorsements to insureds who have received evidences of coverage in compliance with 211 CMR 52.13, provided, that a completely revised evidence of coverage shall be issued to at least one adult insured in each household residing in Massachusetts at least once every five years." **Please confirm that the carrier will comply with this requirement.**

_____ According to 211 CMR 52.13(6), "[e]very evidence of coverage described in 211 CMR 52.13 must contain the effective date, date of issue and, if applicable, expiration date."

_____ Early in 2002, the Division became aware that certain providers in the Massachusetts market intended to modify their practices in April 2002 by charging an annual fee to members as a condition to continue to be part of the providers' panel of patients. The Division was formally requested by certain carriers to opine as to whether carriers would be permitted to continue to include providers within their managed care networks if those providers required such fees as a condition for treatment. As is noted in a letter dated March 6, 2002 to Tufts Health Plan, the Division's General Counsel indicated that it does not believe that the providers' annual fee proposal "violates the current statutory and regulatory framework governing contracts between carriers and providers." The Division's General Counsel's letter of March 6, 2002 instructs all carriers to monitor its network of providers, and if any network provider does require patients to pay an annual fee as a condition for inclusion within that provider's panel of patients, the carrier amend evidences of coverage and other disclosures to make clear that any services that are represented to be part of a provider's annual service agreement are part of that separate agreement and not part of the carrier's health plan coverage

Required Disclosures

According to 211 CMR 52.14(1)(a)-(e), "[a] carrier shall provide to at least one adult insured in each household upon enrollment, and to a prospective insured upon request, the following information:

_____ (a) a statement that physician profiling information, so-called, may be available from the Board of Registration in Medicine for physicians licensed to practice in Massachusetts;

_____ (b) a summary description of the process by which clinical guidelines and utilization review criteria are developed;

_____ (c) the voluntary and involuntary disenrollment rate among insureds of the carrier;

1. For the purposes of 211 CMR 52.14(1)(c), carriers shall exclude all administrative disenrollments, insureds who are disenrolled because they have moved out of a health plan's service area, insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or insureds who lose coverage under an employer-sponsored plan because they have ceased employment or because their employer group has cancelled coverage under the plan, reduced the numbers of hours worked, retired or died.
2. For the purposes of 211 CMR 52.14(1)(c), the term "voluntary disenrollment" means that an insured has terminated coverage with the carrier for nonpayment of premium.
3. For the purposes of 211 CMR 52.14(1)(c), the term "involuntary disenrollment" means that a carrier has terminated the coverage of the insured due to any of the reasons contained in 211 CMR 52.13(1)(i)(2) and (3).

(d) A notice to insureds regarding emergency medical conditions that states all of the following:

_____ 1. that insureds have the opportunity to obtain health care services for an emergency medical condition, including the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever the insured is confronted with an emergency medical condition which in the judgment of a prudent layperson would require pre-hospital emergency services;

_____ 2. that no insured shall in any way be discouraged from using the local pre-hospital emergency medical service system, the 911 telephone number, or the local equivalent;

_____ 3. that no insured will be denied coverage for medical and transportation expenses incurred as a result of such emergency medical condition; and

_____ 4. if the carrier requires an insured to contact either the carrier or its designee or the primary care physician of the insured within 48 hours of receiving emergency services, that notification already given to the carrier, designee or primary care physician by the attending emergency physician shall satisfy that requirement.

_____ (e) a description of the Office of Patient Protection and a statement that the information specified in 211 CMR 52.16 is available to the insured or prospective insured from the Office of Patient Protection."

_____ According to 211 CMR 52.14(3), "[e]very disclosure described in 211 CMR 52.14 must contain the effective date, date of issue and, if applicable, expiration date."

_____ According to 211 CMR 52.14(4) and (5), "[c]arriers shall submit material changes to the disclosures required by 211 CMR 52.14 to the Bureau at least 30 days before their effective dates" [and] "to at least one adult insured in every household residing in Massachusetts at least once every two years." **Please confirm that the carrier will comply with this requirement.**

_____ Early in 2002, the Division became aware that certain providers in the Massachusetts market intended to modify their practices in April 2002 by charging an annual fee to members as a condition to continue to be part of the providers' panel of patients. The Division was formally requested by certain carriers to opine as to whether carriers would be permitted to continue to include providers within their managed care networks if those providers required such fees as a condition for treatment. As is noted in a letter dated March 6, 2002 to Tufts Health Plan, the Division's General Counsel indicated that it does not believe that the providers' annual fee proposal "violates the current statutory and regulatory framework governing contracts between carriers and providers." The Division's General Counsel's letter of March 6, 2002 instructs all carriers to monitor its network of providers, and if any network provider does require patients to pay an annual fee as a condition for inclusion within that provider's panel of patients, to report to the Division which of the network's providers will be unavailable to members who do not or cannot pay the annual fee to be part of that providers' panel of patients.

Requirements for Provider Directories as outlined in 211 CMR 52.15

_____ According to 211 CMR 52.15(1)(a)-(c), "[a] carrier shall provide a provider directory to at least one adult insured in each household upon enrollment and to a prospective or current insured upon request. Annually, thereafter, a carrier shall provide to at least one adult insured in each household, or in the case of a group policy, to the group representative, a provider directory.

_____ (a) The provider directory must contain a list of health care providers in the carrier's network available to insureds residing in Massachusetts, organized by specialty and by location and summarizing for each such provider the method used to compensate or reimburse such provider.

1. Nothing in 211 CMR 52.15(1)(a) shall be construed to require disclosure of the specific details of any financial arrangements between a carrier and a provider.

2. A carrier will be deemed to be in compliance with 211 CMR 52.15(1)(a) if the method of compensation is identified at least as specifically as "fee-for service" or "capitation."

3. If any specific providers or type of providers requested by an insured are not available in said network, or are not a covered benefit, such information shall be provided in an easily obtainable manner.

_____ (b) The provider directory must contain a toll-free number that insureds can call to determine whether a particular health care provider is affiliated with the carrier.

_____ (c) The provider directory must contain an internet website address that insureds can visit to determine whether a particular provider is affiliated with the carrier."

_____ According to 211 CMR 52.15(2), "[c]arriers that issued provider directories prior to January 1, 2001 shall be deemed to have met the requirements of 211 CMR 52.15(1) if during the year between July 1, 2001 and June 30, 2002 the carrier delivers a provider directory to at least one adult insured in each household and to any new enrollee on or after July 1, 2001." **Please confirm that the carrier complied with this requirement.**

_____ According to 211 CMR 52.15(3), "[a] carrier shall be deemed to have met the requirements of 211 CMR 52.15(1) if the carrier provides to at least one adult insured in each household, or in the case of a group policy, to the group representative, at least once per calendar year an addendum, insert, or other update to the provider directory originally provided under 211 CMR 52.15(1), and updates its toll-free number within 48 hours and internet website as soon as practicable. A carrier shall not be required to provide a provider directory upon enrollment if a provider directory is provided to the prospective or current insured, or in the case of a group policy, to the group representative, during applicable open enrollment periods." **Please explain how the carrier complies with this requirement.**

_____ According to 211 CMR 52.15(4), "[e]very provider directory described in 211 CMR 52.15 must contain the effective date, date of issue and expiration date if applicable."

_____ Early in 2002, the Division became aware that certain providers in the Massachusetts market intended to modify their practices in April 2002 by charging an annual fee to members as a condition to continue to be part of the providers' panel of patients. The Division was formally requested by certain carriers to opine as to whether carriers would be permitted to continue to include providers within their managed care networks if those providers required such fees as a condition for treatment. As is noted in a letter dated March 6, 2002 to Tufts Health Plan, the Division's General Counsel indicated that it does not believe that the providers' annual fee proposal "violates the current statutory and regulatory framework governing contracts between carriers and providers." The Division's General Counsel's letter of March 6, 2002 instructs all carriers to monitor its network of providers, and if any network provider does require patients to pay an annual fee as a condition for inclusion within that provider's panel of patients, amend provider directories to show that certain providers will be unavailable to members who do not or cannot pay the annual fee to be part of the providers' panel."

As noted in Bulletin No. 02-07, in meeting the provisions of Chapter 80 of the Acts of 2000 ("Chapter 80"), carriers are to provide or arrange for the "full range of mandated services, including specific treatment modalities appropriate for all ages of patients and all types of covered mental conditions." In addition, it is noted that carriers are to have "sufficient numbers of providers available in the network so that no patient must wait a medically inappropriate amount of time to receive care for acute conditions" and that "care is being delivered promptly and appropriately and that insureds are being provided adequate access as required by law." In order to satisfy the provisions of Chapter 80 and Bulletin No. 02-07, it would appear that provider directories should include lists that address at least the following types of behavioral health providers:

_____ (a) general behavioral health providers;
_____ (b) child/pediatric and adolescent behavioral health providers;
_____ (c) geriatric behavioral health providers;
_____ (d) substance abuse providers or addictionologists; and
_____ (e) eating disorder specialists.

_____ According to Chapter 80, carriers are required to provide or arrange for "a range of inpatient, intermediate, and outpatient services that shall permit medically necessary and active and noncustodial treatment for said mental disorders to take place in the least restrictive clinically appropriate setting . . . inpatient services may be provided in a general hospital licensed to provide such services, in a facility under the direction and supervision of the department of mental health, in a private mental hospital licensed by the department of mental health, or in a substance abuse facility licensed by the department of public health. Intermediate services shall include, but not be limited to, Level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health. Outpatient services may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, or a professional office, or through home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his [or her] license."

_____ Consistent with the requirements of 211 CMR 52.15(1)(a), indicate next to each provider in the directory their professional licensure designation(s) and clarify with footnotes or other prominent notes whether providers are or are not taking new patients and if they only see patients in certain settings (for example, in an inpatient or intermediate care setting).

HMOs WITH INSURED PREFERRED PROVIDER PLANS

NOTE: ***For newly filed Insured Preferred Provider Plans please use the Insured Preferred Provider Plan checklist***

Definitions from M.G.L. c. 176I, § 1 and 211 CMR 51.03 (if used)

_____ Preferred Provider, "a health care provider, group of health care providers or a network of providers who have contracted with an organization to provide specified covered services in the context of a preferred provider arrangement."

_____ Preferred Provider Arrangement ("PPA"), "a contract between or on behalf of an organization and a preferred provider that complies with the requirements of M.G.L. c. 176I and 211 CMR 51.00."

_____ Preferred Provider Plan, "an insured health benefit plan offered by an organization that provides incentives for covered persons to receive health care services from preferred providers in the context of a preferred provider arrangement."

Insured Preferred Provider Plans in general as outlined in 211 CMR 51.04

_____ According to 211 CMR 51.04(1)(a), an insured preferred provider plan is to include "[a] narrative description of the preferred provider plan to be offered."

_____ According to 211 CMR 51.04(1)(b), an insured preferred provider plan is to include "[a] description of the geographical area in which the preferred provider plan is to be offered, including a map of the area with the locations of all preferred providers."

_____ According to 211 CMR 51.04(1)(c), an insured preferred provider plan is to include "[a] description of the manner in which covered health care services and other benefits may be obtained by persons using the preferred provider plan, including any requirement that covered persons select a gatekeeper provider."

_____ According to 211 CMR 51.04(1)(g)(2), an insured preferred provider plan is to include "[a] description of any provision for covered services to be payable at the preferred level until an adequate network has been established for a particular service or provider type."

_____ According to 211 CMR 51.04(1)(g)(4), an insured preferred provider plan is to include "[a] description of the incentives for covered persons to use the services of preferred providers."

_____ According to 211 CMR 51.04(1)(g)(5), an insured preferred provider plan is to include "[a] description of any provisions that allow covered persons to obtain covered health care services from a non-preferred provider at the benefit level for the same covered health care service rendered by a preferred provider."

_____ According to 211 CMR 51.04(1)(g)(8), an insured preferred provider plan is to include "[a] description of any provisions within the preferred provider plan for holding covered persons financially harmless for payment denials by, or on behalf of, the organization for improper utilization of covered health care services caused by preferred providers."

_____ According to 211 CMR 51.04(1)(i)(1), an insured preferred provider plan is to include "[a] description of the arrangements to be used by the organization to protect covered members from financial liability in the event of financial impairment or insolvency of any preferred provider that assumes financial risk."

Requirements of the Evidence of Coverage as outlined in 211 CMR 51.05

According to 211 CMR 51.05(2)(a)-(d), "[t]he evidence of coverage must also include the following in clear and understandable language:

_____ (a) a complete description of the benefit differential between services offered by preferred and non-preferred providers;

_____ (b) Provisions that if a covered person receives emergency care and cannot reasonably reach a preferred provider, payment for such care will be made at the same level and in the same manner as if the covered person had been treated by a preferred provider;

_____ (c) Benefit levels for covered health care services rendered by non-preferred providers must be at least 80% of the benefit levels for the same covered health care services rendered by preferred providers. Payments made to non-preferred providers shall be a percentage of the provider's fee, up to a usual and customary charge, and not a percentage of the amount paid to preferred providers. The 80% requirement shall be met if the coinsurance percentage for a covered health care service rendered by a non-preferred provider is no more than 20 percentage points greater than the highest coinsurance percentage for the same covered health care services rendered by a preferred provider, excluding reasonable deductibles and copayments; and

_____ (d) A description of all benefits required to be provided by law in accordance with all of the provisions of the organization's enabling or licensing statutes."

Reporting Requirements as outlined in 211 CMR 51.06

_____ According to 211 CMR 51.06(1), "[e]ach organization offering a preferred provider plan shall file with the Commissioner any material changes or additions to the material previously submitted on or before their effective date, including amendments to the evidence of coverage and significant changes to the lists of preferred providers." **Please confirm that the carrier will comply with this requirement.**

_____ According to 211 CMR 51.06(2), "[e]ach organization offering a preferred provider plan shall annually file with the Commissioner, within 120 days of the close of its fiscal year, a report covering its prior fiscal year. The annual report shall include at least the following information in a format specified by the Commissioner: (a) A summary of the number of covered persons in preferred provider plans; (b) A summary of the utilization experience of persons covered by preferred provider plans; and (c) A current provider directory which lists preferred providers by specialty and geographic area." **Please confirm that the carrier will comply with these requirements.**

CONTINUATION OF COVERAGE PROVSIONS

_____ **Plant Closing.** According to M.G.L. c. 176G, § 4A, there is a 90-day eligibility for continued coverage in the event of a plant closing or partial plant closing.

_____ **Divorce or Separation**: According to M.G.L. c. 176G, § 5A(a)-(b), there must be a provision for continuation of coverage for group hospital, surgical, medical, or dental insurance in the event of divorce or separation, including the following provisions:

(a) Ex-spouse of the group plan member shall be and will remain eligible for continued group coverage under the policy without additional premium or examination (unless the divorce or separation judgment specifies otherwise). Such coverage continues without additional premium until either spouse remarries.

(b) If the group plan member remarries, the ex-spouse can, if so provided in the divorce judgment, continue to be covered as a member of the group. There may be additional premium, subject to the approval of the Commissioner (additional premium rates must be just and reasonable in accordance with the additional insuring risks involved).

_____ **Small Group**. There must be a provision for continuation of coverage for any individual, general, blanket or group policy of health, accident and sickness insurance ***(excludes supplements to Medicare or other governmental programs)*** if sold to an eligible small business or group with between 2-19 employees and the provisions for continuation of coverage should be in compliance with M.G.L. c. 176J, § 9.

_____ **Group Health Care Insurers.** According to 940 CMR 9.04, it shall be considered an unfair and deceptive act or practice in violation of M.G.L. c. 93A, § 2, for a carrier to deny a member's claim for covered health care services on the grounds that, prior to the date covered health care services were received, the employer's plan has been terminated for nonpayment of premiums, unless the carrier has sent written notice of the termination to the member prior to the date the covered health care services were received in the manner set forth in 940 CMR 9.05.

MANDATED BENEFITS

Requirements for emergency services provided to members for emergency medical conditions

_____ According to M.G.L. c. 176G, § 5(b), "[a] health maintenance organization shall cover emergency services provided to members for emergency medical conditions. After the member has been stabilized for discharge or transfer, the health maintenance organization or its designee may require a hospital emergency department to contact the physician on-call designated by the health maintenance organization or its designee for authorization of post-stabilization services to be provided. The hospital emergency department shall take all reasonable steps to initiate contact with the health maintenance organization or its designee within 30 minutes of stabilization. Such authorization shall be deemed granted if the health maintenance organization or its designee has not responded to said call within 30 minutes…in the event the attending physician and said on-call physician do not agree on what constitutes appropriate medical treatment, the opinion of the attending physician shall prevail and such treatment shall be considered appropriate treatment for an emergency medical condition provided that such treatment is consistent with generally accepted principles of professional medical practice and a covered benefit under the member's evidence of coverage." (See also Bulletin No. 00-14)

_____ According to M.G.L. c. 176G, § 5(c), "[a] health maintenance organization may require a member to contact either the health maintenance organization or its designee or the primary care physician of the member within 48 hours of receiving such emergency services, but notification already given to the health maintenance organization or to said primary care physician by the attending physician shall satisfy the requirements of this paragraph."

_____ According to M.G.L. c. 176G, § 5(e), "[a] health maintenance organization shall clearly state in its brochures, contracts, policy manuals and printed materials that members shall have the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever an enrollee is confronted with an emergency medical condition which in the judgment of a prudent layperson would require pre-hospital emergency services. No member shall in any way be discouraged from using the local pre-hospital emergency medical service system, the 911 telephone number, or the local equivalent, or be denied coverage for medical and transportation expenses incurred as a result of an emergency medical condition."

Mental Health Parity

_____ **Biologically Based Mental Disorders**. According to M.G.L. c. 176G, § 4M(a), "[a] health maintenance contract issued or renewed within or without the commonwealth shall provide mental health benefits on a nondiscriminatory basis to residents of the commonwealth and to all members or enrollees having a principal place of employment in the commonwealth for the diagnosis and treatment of the following biologically-based mental disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, referred to in this section as ""the DSM": (1) schizophrenia, (2) schizoaffective disorder, (3) major depressive disorder, (4) bipolar disorder, (5) paranoia and other psychotic disorders, (6) obsessive-compulsive disorder, (7) panic disorder, (8) delirium and dementia, (9) affective disorders, and (10) any biologically-based mental disorders appearing in the DSM that are scientifically recognized and approved by the commissioner of the department of mental health in consultation with the commissioner of the division of insurance."

_____ **Rape-Related Mental or Emotional Disorders**. According to M.G.L. c. 176G, § 4M(b), "any such health maintenance contract shall also provide benefits on a non-discriminatory basis for the diagnosis and treatment of rape-related mental or emotional disorders to victims of a rape or victims of an assault with intent to commit rape, as defined by sections 22 and 24 of chapter 265 [of the Massachusetts General Laws], whenever the costs of such diagnosis and treatment exceed the maximum compensation awarded to such victims pursuant to subparagraph (C) of paragraph (2) of subsection (b) of section 3 of chapter 258C [of the Massachusetts General Laws]."

_____ **Children and Adolescents under the age of 19**. According to M.G.L. c. 176G, § 4M(c), "any such health maintenance contract shall also provide benefits on a non-discriminatory basis to children and adolescents under the age of 19 for the diagnosis and treatment of non-biologically-based mental, behavioral or emotional disorders, as described in the most recent edition of the DSM, which substantially interfere with or substantially limit the functioning and social interactions of such a child or adolescent; provided, that said interference or limitation is documented by and the referral for said diagnosis and treatment is made by the primary care physician, primary pediatrician or a licensed mental health professional of such a child or adolescent or is evidenced by conduct, including, but not limited to: (1) an inability to attend school as a result of such a disorder, (2) the need to hospitalize the child or adolescent as a result of such a disorder, (3) a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others. The health maintenance organization shall continue to provide such benefits to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent's nineteenth birthday until said course of treatment, as specified in said adolescent's treatment plan, is completed and while the benefit contract under which such benefits first became available remains in effect, or subject to a subsequent benefits contract which is in effect."

_____ According to Bulletin No. 00-10, "[c]arriers must . . . continue to provide non-discriminatory mental health benefits . . . to any such adolescent who continues coverage under any other subsequent contract. Relative to a carrier's responsibility to continue to provide the mandated benefit for such an adolescent when he/she turns 19 and, in certain cases, ceases to qualify as a dependent under his/her parent's health plan, carriers must continue to provide the mandated mental health benefits. In this case, carriers may charge the affected person his/her usual premium in order to qualify for the continuation of this mandated benefit or offer the person the option to pay for continuation of the health plan coverage under federal (COBRA) or state continuation provisions. . . . [T]he Division suggests that carriers make clear that if COBRA coverage is selected then all plan benefits will be available. If COBRA coverage is not selected, any premium paid to continue the mental health benefits beyond age 19 will continue Chapter 80 benefits only and COBRA eligibility will not be extended."

_____ **Parity**. According to M.G.L. c. 176G, § 4M(d), "[a]ny such health maintenance contract shall be deemed to be providing such coverage on a non-discriminatory basis if the health maintenance contract does not contain any annual or lifetime dollar or unit of service limitation on coverage for the diagnosis and treatment of said mental disorders which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the diagnosis and treatment of physical conditions."

_____ **All Other Mental Disorders**. According to M.G.L. c. 176G, § 4M(e), "[a]ny such health maintenance contract shall also provide benefits for the diagnosis and treatment of all other mental disorders not otherwise provided for in this section and which are described in the most recent edition of the DSM during each 12 month period for a minimum of 60 days of inpatient treatment and for a minimum of 24 outpatient visits."

_____ According to Bulletin No. 00-10, "[a]lthough these other mandated mental health benefits can be capped according to the number of days of inpatient treatment or outpatient visits, no other limitations, coinsurance, copayment, deductibles or other cost-sharing may be applied toward these benefits except as are applied to covered medical services within the plan."

_____ **Psychopharmacological Services and Neuropsychological Assessment Services.** According to M.G.L. c. 176G, § 4M(i), "psychopharmacological services and neuropsychological assessment services shall be treated as a medical benefit and shall be covered in a manner identical to all other medical services."

_____ **Mental Health Related Alcohol and Chemical Dependency Treatment *(Except a policy which provides supplemental coverage to Medicare or other governmental programs)*** According to M.G.L. c. 176G, § 4M(f), "[t]he limitation on benefits for the treatment of alcoholism or chemical dependency established by subdivision (H) of section 110 of chapter 175 and by section 4 [of the Massachusetts General Laws] shall not apply when said treatment is rendered in conjunction with treatment for mental disorders pursuant to this section nor shall said limitation on benefits established by said subdivision (H) of said section 110 and by said section 4 [of the Massachusetts General Laws] impose or be construed to impose any restriction or limitation in connection with benefits for the treatment of mental disorders pursuant to this section."

General Provisions regarding Alcoholism (***limitations as set forth under M.G.L. c. 175, § 110(H)(a)-(b) except a policy which provides supplemental coverage to Medicare or other governmental programs)***

_____ Inpatient: Minimum of 30 days per calendar year in an accredited or licensed hospital or in any other public or private facility providing services especially for the detoxification or rehabilitation of intoxicated persons or alcoholics and which is licensed by the Department of Public Health for those services, or in a residential alcohol treatment program. Notwithstanding the foregoing provisions, the period of confinement may be calculated by substituting, solely at the insurer's option and, where medically appropriate, two days of outpatient day treatment for one day of inpatient hospital care. "Outpatient hospital day" shall be defined by the division of insurance. (See also M.G.L. c. 176A, § 10 and c. 176B, § 4A1/2, and Bulletin No. 97-04)

_____ Outpatient: Minimum of $500 over a 12-month period for services furnished by an accredited or licensed hospital or any public or private facility or portion thereof providing services especially for the rehabilitation of intoxicated persons or alcoholics and which is licensed by the department of public health for those purposes. Consultants or treatment sessions furnished by a facility pursuant to M.G.L. c. 175, § 110(H)(b) shall be rendered by a physician or psychotherapist fully licensed under the provisions of M.G.L. c. 112 who devotes a substantial portion of his time treating intoxicated persons or alcoholics. (See also M.G.L. c. 176A, § 10, and c. 176B, § 4A1/2, and Bulletin No. 97-04)

_____ **Where Services may be Provided**. According to M.G.L. c. 176G, § 4M(g), "[b]enefits authorized pursuant to this section shall consist of a range of inpatient, intermediate, and outpatient services that shall permit medically necessary and active and noncustodial treatment for said mental disorders to take place in the least restrictive clinically appropriate setting. For purposes of this section, inpatient services may be provided in a general hospital licensed to provide such services, in a facility under the direction and supervision of the department of mental health, in a private mental hospital licensed by the department of mental health, or in a substance abuse facility licensed by the department of public health. Intermediate services shall include, but not be limited to, Level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health. Outpatient services may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his license."

_____ **Disclosure**. According to M.G.L. c. 176G, § 4M(h), "[n]o health maintenance organization shall require as a condition to receiving benefits mandated by this section consent to the disclosure of information regarding services for mental disorders under different terms and conditions than consent is required for disclosure of information for other medical conditions. A determination by a health maintenance organization that services authorized pursuant to this section are not medically necessary shall only be made by a licensed mental health professional; provided, that this provision shall not be construed as applying to denials of service resulting from an insured's lack of insurance coverage or use of a facility or professional which has not entered into a negotiated agreement with the health maintenance organization. The benefits provided in any health maintenance contract pursuant to this section shall meet all other terms and conditions of the health maintenance contract not inconsistent with this section."

Preventive and Primary Care Services for Children

_____ **Dependent Definition**. According to M.G.L. c. 176G, § 4, a dependent includes "newborn infants and newborn infants of a dependent of a policyholder domiciled in the commonwealth . . . immediately from the moment of birth and thereafter . . . [and] adoptive children of a policyholder domiciled in the commonwealth . . . immediately from the date of the filing of a petition to adopt . . . and thereafter if the child has been residing in the home of the policyholder . . . as a foster child for whom the holder has been receiving foster care payments, or, in all other cases, immediately from the date of placement by a licensed placement agency of the child for purposes of adoption in the home of a policyholder . . . and thereafter."

_____ According to M.G.L. c. 176G, § 4, "[i]f payment of a specific premium is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child or of filing of a petition to adopt a foster child or of placement of a child for purposes of adoption and payment of the required premium must be furnished to the insurer or indemnity corporation. For the purposes of this section "notification" may mean submission of a claim."

_____ According to M.G.L. c. 176G, § 4 "[t]he coverage for newly born infants and adoptive children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, or premature birth."

_____ According to M.G.L. c. 176G, § 4 "[s]uch coverage [for newly born infants and adoptive children] shall also include those special medical formulas which are approved by the commissioner of the department of public health, prescribed by a physician, and are medically necessary for treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, or methylmalonic acidemia in infants and children or medically necessary to protect the unborn fetuses of pregnant women with phenylketonuria."

_____ According to M.G.L. c. 176G, § 4 "[s]uch coverage [for newly born infants and adoptive children] shall also include screening for lead poisoning as required by the regulations promulgated pursuant to section one hundred and ninety-three of chapter one hundred and eleven [of the Massachusetts General Laws; 105 CMR 460.050]."

According to M.G.L. c. 176G, § 4, policies must include coverage for the following services to the dependent child of an insured member from the date of birth through the attainment of six (6) years of age:

_____ "physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening, and assessment at the following intervals: six (6) times during the child's first year after birth, three [3] times during the next year, annually until age six."

_____ "Such services shall also include hereditary and metabolic screening at birth, appropriate immunizations, and tuberculin tests, hematrocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the physician."

_____ According to M.G.L. c. 176G, § 4, policies shall provide "coverage for the cost of a newborn hearing screening tests to be performed before the newborn infant is discharged from the hospital or birthing center to the care of the parent or guardian or as provided by regulations of the department of public health." (See also Bulletin No. 98-13)

Early Intervention

_____ According to M.G.L. c. 176G, § 4, "[t]he dependent coverage of any such policy shall also provide coverage for medically necessary early intervention services delivered by certified early intervention specialists, as defined in the early intervention operational standards by the department of public health and in accordance with applicable certification requirements. Such medically necessary services shall be provided by early intervention specialists who are working in early intervention programs certified by the department of public health, as provided in sections 1 and 2 of chapter 111G [of the Massachusetts General Laws], for children from birth until their third birthday. Reimbursement of costs for such services shall be part of a basic benefits package offered by the insurer or a third party, with a maximum benefit of $3,200 per year per child and an aggregate benefit of $9,600 over the total enrollment period."

Maternity Coverage
(Except a policy which provides supplemental coverage to Medicare or other governmental programs)

_____ According to M.G.L. c. 176G, § 4, policies "shall provide benefits . . . for the expense of prenatal care, childbirth and post partum care to the same extent as provided for medical conditions not related to pregnancy." (See also Bulletin Nos. 97-01 and 96-02)

_____ According to M.G.L. c. 176G, § 4, policies "shall provide coverage of a minimum of forty-eight [48] hours of in-patient care following a vaginal delivery and a minimum of ninety-six [96] hours of in-patient care following a caesarean section for a mother and her newly born child. Any decision to shorten such minimum coverages shall be made by the attending physician in consultation with the mother. Any such decision shall be made in accordance with rules and regulations promulgated by the department of public health. Said regulations shall be relative to early discharge, defined as less than forty-eight hours for a vaginal delivery and ninety-six hours for a caesarean delivery, and post-delivery care and shall include, but not be limited to, home visits, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests; provided, however, that the first home visit shall be conducted by a registered nurse, physician, or certified nurse midwife; and provided, further, that any subsequent home visit determined to be clinically necessary shall be provided by a licensed health care provider." (See also Bulletin Nos. 97-01 and 96-02)

_____ According to M.G.L. c. 176G, § 4, "[f]or the purposes of this section [M.G.L. c. 176G, § 4] attending physician shall include the attending obstetrician, pediatrician, or certified nurse midwife attending the mother and newly born child." (See also Bulletin Nos. 97-01 and 96-02)

Infertility Benefits

(Except a policy which provides supplemental coverage to Medicare or other governmental programs)

_____ According to M.G.L. c. 176G, § 4, policies "shall provide, to the same extent that benefits are provided for other pregnancy-related procedures, coverage for medically necessary expenses of diagnosis and treatment of infertility to persons residing within the commonwealth . . . [and] 'infertility' shall mean the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year." (See also Bulletin No. 95-08)

_____ According to 211 CMR 37.05, "[s]ubject to any reasonable limitations as described in 211 CMR 37.08, insurers shall provide benefits for all non-experimental infertility procedures including, but not limited to:
(1) Artificial Insemination (AI);
(2) In Vitro Fertilization and Embryo Placement (IVF-EP).
(3) Gamete Intra fallopian Transfer (GIFT).
(4) Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any.
(5) Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility.
(6) Zygote Intrafallopian Transfer (ZIFT)."

_____ According to 211 CMR 37.06, "[I]nsurers shall not impose exclusions, limitations or other restrictions on coverage for infertility-related drugs that are different from those imposed on any other prescription drugs."

_____ According to 211 CMR 37.08(1), "[n]o insurer shall impose deductibles, copayments, coinsurance, benefit maximums, waiting periods or any other limitations on coverage for required infertility benefits which are different from those imposed upon benefits for services not related to infertility. **Please confirm that the carrier complies with this requirement.**

_____ According to 211 CMR 37.08(2), "[n]o insurer shall impose pre-existing condition exclusions or pre-existing condition waiting periods on coverage for required infertility benefits. No insurer shall use any prior diagnosis of or prior treatment for infertility as a basis for excluding, limiting or otherwise restricting the availability of coverage for required infertility benefits."

_____ According to 211 CMR 37.09, "[i]nsurers may establish reasonable eligibility requirements, based upon the insured's medical history, and reasonable provider contracting standards. Eligibility requirements based solely on arbitrary factors including, but not limited to, number of attempts or dollar amounts, shall be presumed invalid. These requirements and standards shall be maintained in written form and shall be available to any insured and/or the Commissioner upon request. Standards or guidelines developed by the American Society for Reproductive Medicine or the American College of Obstetrics and Gynecology may serve as a basis for these eligibility and contracting requirements." **Please submit a copy of the carrier's infertility benefit eligibility requirements**.

Hormone Replacement Therapy and Contraceptive Services
(Except contracts purchased by a subscriber that is a church or qualified church-controlled organization)

As outlined in Bulletin No. 02-09, 2002 Mass. Acts 49 (Chapter 49), An Act Providing Equitable Coverage of Services Under health Plans, added section 4O to M.G.L. c. 176G. Chapter 49 "will apply to all policies, contracts, plans and certificates of insurance issued or delivered within the commonwealth on or after January 1, 2003 and to policies, contracts, agreements, plans and certificates of insurance in effect before that date upon renewal on or after January 1,2 003."

_____ According to Bulletin No. 02-09, "Chapter 49 provides that insured polices, contracts, agreements, plans and certificates of coverage that provide benefits for outpatient services shall provide hormone replacement therapy services for peri- and post-menopausal women and outpatient contraceptive services under the same terms and conditions as for such other outpatient services. Outpatient contraceptive services are defined to include consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of all contraceptive methods to prevent pregnancy that have been approved by the United States Food and Drug Administration."

_____ According to Bulletin No. 02-09, "Chapter 49 also provides that insured policies, contracts, agreements, plans and certificates of coverage that are delivered, issued or renewed within or without the commonwealth that provide benefits for outpatient prescription drugs and devices shall provide benefits for hormone replacement therapy for peri- and post-menopausal women and outpatient prescription drugs or devices which have been approved by the United States Food and Drug Administration (FDA) under the same terms and conditions as for other prescription drugs or devices, provided that in covering all FDA approved prescription contraceptive methods, carriers may us a closed or restricted formulary."

Cytologic screening and mammographic examination expense benefits

_____ According to M.G.L. c. 176G, § 4, policies "shall provide benefits for the expense of cytologic screening and mammographic examination. Said benefits shall be at least equal to the following minimum requirements: (a) in the case of benefits for cytologic screening, said benefits shall provide for an annual cytologic screening for women eighteen years of age and older; and (b)in the case of benefits for mammographic examination said benefits shall provide for a baseline mammogram for women between the ages of thirty-five and forty and for a mammogram on an annual basis for women forty years of age and older."

Bone Marrow Transplants for Breast Cancer

_____ According to M.G.L. c. 176G, § 4F, "[a]ny group health maintenance contract shall provide coverage for a bone marrow transplant or transplants for persons who have been diagnosed with breast cancer that has progressed to metastatic disease; provided, however, that said person shall meet the criteria established by the department of public health [105 CMR 240.00]."

Federal Mastectomy Mandate

_____ According to the Women's Health and Cancer Rights Act of 1998, "[a] group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and physical complications all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter."

Coverage for Human Leukocyte Antigen Testing for Certain Individuals and Patients
(Except a policy which provides supplemental coverage to Medicare or other governmental programs)

_____ According to M.G.L. c. 176G, § 4N, policies shall provide coverage "for the cost of human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish such member's or enrollee's bone marrow transplant donor suitability. The coverage shall cover the costs of testing for A, B or DR antigens, or any combination thereof, consistent with the rules, regulations and criteria established by the department of public health pursuant to section 218 of chapter 111 [of the Massachusetts General Laws]." (See also Bulletin Nos. 01-16 and 01-04)

Cardiac Rehabilitation Coverage
(Except a policy which provides supplemental coverage to Medicare or other governmental programs)

_____ According to M.G.L. c. 176G, § 4, policies "shall provide benefits for the expense of cardiac rehabilitation. Cardiac rehabilitation shall mean multidisciplinary, medically necessary treatment of persons with documented cardiovascular disease, which shall be provided in either a hospital or other setting and which shall meet standards promulgated by the commissioner of public health after reviewing proposals submitted by the Massachusetts Society for Cardiac Rehabilitation, Inc. and after notice and public hearing on the proposed standards. Such standards shall include, but not be limited to, outpatient treatment which is to be initiated within twenty-six weeks after the diagnosis of such disease [105 CMR 143.00]."

Hospice Care

_____ According to M.G.L. c. 176G, § 4L, "[a]ny group health maintenance contract shall provide coverage for hospice services as defined in section 57D of chapter 111 [of the Massachusetts General Laws] during the life of the patient, to terminally ill patients with a life expectancy of six months or less; provided however, that such services are determined to be appropriate and authorized by the patient's primary care or treating physician and are equivalent to those services provided by a licensed hospice program regulated by the department of public health [105 CMR 141.00]."

Home Health Care Coverage

_____ According to M.G.L. c. 176G, §4C, ""Home care services", shall mean health care services for a patient provided by a public or private home health agency which meets the standards of service of the purchaser of service, provided in a patient's residence; provided, however, that such residence is neither a hospital nor an institution primarily engaged in providing skilled nursing or rehabilitation services. Said services shall include, but not be limited to, nursing and physical therapy. Additional services such as occupational therapy, speech therapy, medical social work, nutritional consultation, the services of a home health aid and the use of durable medical equipment and supplies shall be provided to the extent such additional services are determined to be a medically necessary component of said nursing and physical therapy. Benefits for home care services shall apply only when such services are medically necessary and provided in conjunction with a physician approved home health services plan."

Speech, Hearing and Language Disorders

_____ According to M.G.L. c. 176G, § 4N, policies shall provide "for the expenses incurred in the medically necessary diagnosis and treatment of speech, hearing and language disorders by individuals licensed as speech-language pathologists or audiologists under the provisions of chapter 112 [of the Massachusetts General Laws], if such services are rendered within the lawful scope of practice for such speech-language pathologists or audiologists regardless of whether the services are provided in a hospital, clinic or private office, and if such coverage shall not extend to the diagnosis or treatment of speech, hearing and language disorders in a school-based setting. The benefits provided by this section shall be subject to the same terms and conditions established for any other medical condition covered by such individual or group blanket policy." (See also Bulletin No. 01-03)

Non-prescription Enteral Formulas for Home Use

_____ According to M.G.L. c. 176G, § 4D, "[a] group health maintenance contract shall provide coverage for nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. Coverage for inherited diseases of amino acids and organic acids shall include food products modified to be low protein in an amount not to exceed two thousand five hundred dollars [2,500] annually for any insured individual." (See also Bulletin No. 95-09)

Off-Label Use of Drugs for the treatment of Cancer and HIV/AIDS

_____ According to M.G.L. c. 176G, § 4E, no policy "shall exclude coverage of any such drug used for the treatment of cancer on the grounds that the off-label use of the drug has not been approved by the United States Food and Drug Administration for that indication; provided, however, that such drug is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature, or by the commissioner under the provisions of section forty-seven L [of chapter 175 of the Massachusetts General Laws]. Any coverage of a drug required by this section shall also include medically necessary services associated with the administration of the drug."

_____ According to M.G.L. c. 176G, § 4G, no policy "shall exclude coverage of any such drug for HIV/AIDS treatment on the grounds that the off-label use of the drug has not been approved by the federal food and drug administration for that indication, if such drug is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature, or by the commissioner under the provisions of section forty-seven P of [chapter 175 of the Massachusetts General Laws]. Any coverage of a drug required by this section shall also include medically necessary services associated with the administration of the drug." (See also Bulletin Nos. 97-09, 96-06, 96-05, and 95-05)

Diabetes Cost Reduction
(Except a policy which provides supplemental coverage to Medicare or other governmental programs)

_____ According to M.G.L. c. 176G, § 4H, policies shall provide "coverage for the following items if such items are within a category of benefits or services for which coverage is otherwise afforded by the contract, have been prescribed by a health care professional legally authorized to prescribe such items and if the items are medically necessary for the diagnosis or treatment of insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes: blood glucose monitors; blood glucose monitoring strips for home use; voice-synthesizers for blood glucose monitors for use by the legally blind; visual magnifying aids for use by the legally blind; urine glucose strips; ketone strips; lancets; insulin; insulin syringes; prescribed oral diabetes medications that influence blood sugar levels; laboratory tests, including glycosylated hemoglobin, or HbAlc, tests; urinary protein/microalbumin and lipid profiles; insulin pumps and insulin pump supplies; insulin pens, so-called; therapeutic/molded shoes and shoe inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the treating doctor and prescribed by a podiatrist or other qualified doctor and furnished by a podiatrist, orthotist, prosthetist or pedorthist; supplies and equipment approved by the Federal Drug Administration for the purposes for which they have been prescribed and diabetes outpatient self-management training and education, including medical nutrition therapy, when provided by a certified diabetes health care provider participating with the health maintenance contract or affiliated with a provider participating with the health maintenance contract."

_____ According to Bulletin No. 00-05, "nondiscriminatory treatment of benefits for diabetes-related services is mandated. The Division will consider a carrier to be in compliance . . . if the mandated services and supplies are covered within the following categories of benefits:

- **outpatient services**: outpatient diabetes self-management training and education;
- **laboratory/radiological services**: all laboratory tests and urinary profiles;
- **durable medical equipment**: blood glucose monitors, voice-synthesizers and visual magnifying aids;
- **prosthetics**: therapeutic/molded shoes and shoe inserts; and
- **prescription drugs**: blood glucose monitoring strips, urine glucose strips, ketone strips, lancets, insulin syringes, insulin pumps and insulin pump supplies, insulin pens, insulin and oral medications.

For items in the last category, with the exception of an insulin pump, the Division will consider a carrier to be in compliance if a co-payment is applied for no less than a 30-day supply of the mandated item. The Division will consider it to be a violation . . . if a carrier excludes from a particular category any of the above-noted items for diabetics."

Scalp Hair Prosthesis for Cancer Patients

_____ According to M.G.L. c. 176G, § 4J, "[a] group health maintenance contract which provides coverage for any other prosthesis, shall provide coverage for expenses for scalp hair prostheses worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia; provided, however, that such coverage shall be subject to a written statement by the treating physician that the scalp hair prosthesis is medically necessary; and provided, further, that such coverage shall be subject to the same limitations and guidelines as other prostheses. Scalp hair prosthesis coverage pursuant to this section shall not exceed an amount of $350 per year." (See also Bulletin No. 98-09)

Insurance Coverage of Qualified Clinical Trials
(Except Medicare Supplement Plans or contracts purchased by a subscriber that is a church or qualified church-controlled organization)

As outlined in Bulletin No. 02-13, 2002 Mass. Acts 257 (Chapter 257), An Act Providing Insurance Coverage of Certain Clinical Trials, which adds the following Massachusetts health insurance statutes: M.G.L. c. 175, § 110L, c. 176A, § 8X, c. 176B, § 4X, and c. 176G, § 4P. Chapter 257 "will apply to all policies, contracts, agreements or certificates issued or delivered within the Commonwealth on or after January 1, 2003 and for those in existence before that date, as of the renewal date on or after January 1, 2003."

_____ According to Bulletin No. 02-13, "Chapter 257 requires that insured policies, contracts, agreements, plans and certificates of coverage provide coverage for patient care service furnished pursuant to qualified clinical trials to the same extent as they would be covered and reimbursed if the patient did not receive care in a qualified clinical trial. The term "patient care service" is defined as a health care item or service that is furnished to an individual enrolled in a qualified clinical trial which is consistent with the usual and customary standard of care for someone with the patient's diagnosis, is consistent with the study protocol for the clinical trial, and would be covered if the patient did not participate in the clinical trial. . . . Chapter 257 indicates that coverage for qualified clinical trials shall be subject to all the other terms and conditions of the policy, including, but not limited to, requiring the use of participating providers, provisions related to utilization review and the applicable agreement between the provider and the carrier."

_____ According to Bulletin No. 02-13, "Chapter 257 further defines a clinical trial to be a "qualified clinical trial" if it meets the following conditions:

(1) the clinical trial is to treat cancer;
(2) the clinical trial has been peer reviewed and approved by one of the following:
(i) United States National Institute of Health;
(ii) a cooperative group or center of the National Institute of Health;
(iii) a qualified nongovernmental research entity identified in guidelines issued by the National Institute of Health for center support grants;
(iv) the United States Food and Drug Administration pursuant to an investigational new drug exemption;
(iv) the United States Department of Defense or Veterans Affairs;
(vi) with respect to Phase II, III and IV clinical trails only, a qualified institutional review board.
(3) the facility and personnel conducting the clinical trial are capable of doing so by virtue of there experience and training and treat a sufficient volume of patients to maintain that experience;
(4) with respect to phase I clinical trials, the facility shall be an academic medical center or an affiliated facility and the clinicians conducting the trial shall have staff privileges at said academic medical center;
(5) the patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial;
(6) the patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards;
(7) the available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial;
(8) the clinical trial does not unjustifiably duplicate existing studies; and
(9) the clinical trial must have a therapeutic intent and must, to some extent, assume the effect of the intervention on the patient."

NON-DISCRIMINATION

_____ **Victims of Domestic Abuse**. According to M.G.L. c. 176G, § 19, "[n]o health maintenance organization subject to this chapter, and no officer or agent thereof, shall cancel, refuse to issue or renew, or in any way make or permit any distinction or discrimination in the amount or payment of premiums or rates charged, in the length of coverage, or in any other of the terms and conditions of a health maintenance contract based on information that an individual has been a victim of abuse, as defined by section one of chapter two hundred and nine A [of the Massachusetts General Laws]. No health maintenance organization subject to this chapter, and no officer or agent thereof, shall seek information that such person has been a victim of abuse as defined by said section one of said chapter two hundred and nine A [of the Massachusetts General Laws]. The practices prohibited under this section shall include not only those overtly discriminatory but also practices and devices which are fair in form but discriminatory in practice. Nothing in this section shall be construed as creating a special class of insureds who have been victims of abuse as defined by said section one of said chapter two hundred and nine A [of the Massachusetts General Laws]. Any violation of this section shall constitute an unfair method of competition or an unfair or deceptive act or practice in violation of chapters ninety-three A and one hundred and seventy-six D [of the Massachusetts General Laws]." **Please confirm that the carrier complies with this requirement.**

_____ **Genetic Testing and Privacy Protection.** According to M.G.L. c. 176G, § 24, "[n]o health maintenance organization subject to this chapter, and no officer or agent thereof, shall cancel, refuse to issue or renew, or in any way make or permit any distinction or discrimination in the amount of payment of premium or rates charged, in the length of coverage or in any of the terms and conditions of a health maintenance contact based on genetic information as defined in this section. No health maintenance organizations subject to the provisions of this chapter and no officer of agent thereof, shall require genetic tests or private genetic information, as defined in this section, as a condition of the issuance or renewal of a health maintenance contract. Any violation of this section shall constitute an unfair method of competition or deceptive act or practice in violation of chapters 93A and 176D." [also see Bulletin No. 00-16] **Please confirm that the carrier complies with this requirement.**

MANDATED COVERAGE FROM CERTAIN TYPES OF PROVIDERS

_____ **Licensed Mental Health Professional**. For the purposes of M.G.L. c. 176G, § 4M, a "licensed mental health professional" "shall mean a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist."

_____ **Certified Registered Nurse Anesthetist and Nurse Practitioner**. According to M.G.L. c. 176G, § 4, policies "shall provide benefits for services rendered by a certified registered nurse anesthetist or nurse practitioner designated as such certified registered nurse anesthetist or nurse practitioner by the board of registration in nursing pursuant to the provisions of section eighty B of chapter one hundred and twelve; provided, however, that the following conditions are met: (1) the service rendered is within the scope of the certified registered nurse anesthetist's license or the nurse practitioner's authorization to practice by the board of registration in nursing; and (2) the policy or contract currently provides benefits for identical services rendered by a provider of health care licensed by the commonwealth."

_____ **Podiatrist.** According to M.G.L. c. 176G, § 1, "[a]ny individual who has entered into a group health maintenance contract that provides for any podiatric medical or surgical service which is within the lawful scope of practice of a licensed podiatrist, shall be entitled to such services whether the service is performed by a physician or licensed podiatrist, including authorized referral services on a nondiscriminatory basis."